

Examples of Completed UB-92 Claim Forms

APPROVED OMB NO. 0938-0279

2		3 PATIENT CONTROL NO.	
Woody's Family Care Benson, NC		Example #1 893	
5 FED. TAX NO.	6 STATEMENT COVERED PERIOD THROUGH	7 COVD.	8 N-C.D.
010100	013100		
12 PATIENT NAME Lightyear, Buzz		13 PATIENT ADDRESS	
14 BIRTHDATE	15 SEX	16 MS	17 DATE
01051967			021595
18 OCCURRENCE CODE		19 OCCURRENCE DATE	
33		30	
20 OCCURRENCE CODE		21 OCCURRENCE DATE	
34		30	
22 STAT		23 MEDICAL RECORD NO.	
30			
24		25	
26		27	
28		29	
30		31	
32		33	
34		35	
36		37	
38		39	
40		41	
42		43	
44		45	
46		47	
48		49	

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 599		W8251	010100	31			1
2							2
3 229			010100	31			3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14

**Example of an entire month of Basic ACH/PC
for a facility with 1-30 beds**

23		50 PAYER		51 PROVIDER NO.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56	
A		7801200									
B											
C											
57		DUE FROM PATIENT									
A		58 INSURED'S NAME		59 P.REL.		60 CERT. - SSN - HIC. - ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.	
B		245456123T									
C											
A		63 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION			
B											
C											
67 PRIN. DIAG. CD		68 CODE		69 CODE		70 CODE		71 CODE		72 CODE	
73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD		77 E-CODE		78	
79 P.C.		80 PRINCIPAL PROCEDURE CODE		81 OTHER PROCEDURE CODE		82 ATTENDING PHYS. ID					
83		84 OTHER PROCEDURE CODE		85 OTHER PROCEDURE CODE		86 OTHER PHYS. ID					
87		88 OTHER PROCEDURE CODE		89 OTHER PROCEDURE CODE		90 OTHER PHYS. ID					
84 REMARKS											
85											
86											
87											

88 PHOENIX REPRESENTATIVE
X Woody Cowboy 02-01-00

89 DATE

90

UB-92 HCFA-1450 ORIGINAL

East Coast Family Care Carolina Beach, NC		2 Example #2		3 PATIENT CONTROL NO. 893		APPROVED OMB NO. 0938-0279	
5 FED. TAX NO.		6 STATEMENT COVERING PERIOD FROM 010100 TO 013100		7 COV.D.		8 N.C.D.	
9 C.I.D.		10 L.R.D.		11			
12 PATIENT NAME Smith, John				13 PATIENT ADDRESS			
14 BIRTHDATE 05061945		15 SEX M		16 MS 061585		17 DATE	
18 ADMISSION		19 ICD-9-CM		20 ICD-9-CM		21 D.H.R.	
22 STAT		23 MEDICAL RECORD NO.		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	

Example of an entire month of Basic ACH/PC for a facility with 31 or more beds

50 PAYER		51 PROVIDER NO. 7801700		52 PREL. ICD-9-CM		53 PRIOR PAYMENTS		54 EST. AMOUNT DUE		56													
57 DUE FROM PATIENT																							
58 INSURED'S NAME				59 P.PREL. 9456123P				60 CERT. - SSN - HIC - ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.											
63 TREATMENT AUTHORIZATION CODES				64 ESC				65 EMPLOYER NAME				66 EMPLOYER LOCATION											
67 PRIN. DIAG. CD.		68 ICD-9-CM		69 CODE		70 CODE		71 ICD-9-CM		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD.		77 E-CODE		78	
79 P.C.		80 PRINCIPAL PROCEDURE CODE		81 OTHER PROCEDURE CODE		82 OTHER PROCEDURE CODE		83 OTHER PROCEDURE CODE		84 OTHER PROCEDURE CODE		85 OTHER PROCEDURE CODE		86 ATTENDING PHYS. ID		87 OTHER PHYS. ID		88 OTHER PHYS. ID		89 OTHER PHYS. ID		90	
84 REMARKS												91 PROVIDER REPRESENTATIVE		92 DATE									
												X Sue Pilasim		2-01-00									

UB-92 HCFA-1450 ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Riverfront Manor Fisheland, NC		2 Example #3		3 PATIENT CONTROL NO.		APPROVED OMB NO. 0938-0279	
5 FED. TAX NO.		6 STATEMENT COVERED PERIOD FROM 010100 TO 013100		7 COV.D.		8 N.C.D.	
9 C.I.D.		10 L.R.D.		11		12	
12 PATIENT NAME Livingston, John				13 PATIENT ADDRESS			
14 BIRTHDATE 12251965		15 SEX M		16 MS		17 DATE 021493	
18 HR		19 TYPE I		20 PER		21 D.H.R.	
22 STAT		23 MEDICAL RECORD NO.		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	

Example of an entire month of Basic ACH/PC plus an authorized Enhanced Care code for eating for a facility with 1-30 beds

50 PAYER		51 PROVIDER NO.		52 REL. FROM		53 REL. WITH		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56	
A		B		C		D		E		F		G	
57		58 INSURED'S NAME		59 P. REL.		60 CERT. - SSN - HIC - ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.		63	
A		B		C		D		E		F		G	
64		65 EMPLOYER NAME		66 EMPLOYER LOCATION		67		68		69		70	
A		B		C		D		E		F		G	
71		72		73		74		75		76		77	
78		79		80		81		82		83		84	
A		B		C		D		E		F		G	
85		86		87		88		89		90		91	
A		B		C		D		E		F		G	
92		93		94		95		96		97		98	
A		B		C		D		E		F		G	
99		00		01		02		03		04		05	
A		B		C		D		E		F		G	

UB-92 HCFA-1450

ORIGINAL

89 PROVIDER REPRESENTATIVE
x Bill Rivera
88 DATE
2-1-00
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

APPROVED OMB NO. 0938-0273

Taylor's Family Care Mayberry, NC		2 Example #4		3 PATIENT CONTROL NO. 893	
5 FED. TAX NO.		8 STATEMENT COVERS PERIOD 010100 013100		7 COV.D.	8 N-C.D.
12 PATIENT NAME Fife, Bernard		13 PATIENT ADDRESS			
14 BIRTHDATE 04011940	15 SEX	16 MS	17 DATE 010199	18 HR	19 TYPE L OR R
21 D HR		22 STAT	23 MEDICAL RECORD NO	24 25 26 27 28 29 30 31 CONDITION CODES	
32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT	
42 REV. CD		43 DESCRIPTION		44 HCPCS / RATES	45 SERV. DATE
1	599			W8251	010100
2					31
3	599			W8256	010100
4					31
5	599			W8255	010100
6					31
7	229				010100
8					31
9					
10					
11					
12					
13					
14					

**Example of an entire month of Basic ACH/PC
plus an authorized Enhanced Care code for eating and an
authorized Enhanced Care code for Ambulation/Location
for a facility with 1-30 beds**

50 PAYER		51 PROVIDER NO. 7801500		52 REL. REP. HEL.	53 PRIOR PAYMENTS	54 EST. AMOUNT DUE	55
57		DUE FROM PATIENT					
58 INSURED'S NAME		59 P.REL.		60 CERT. - SSN - HIC - ID NO. 201050607P		61 GROUP NAME	
62 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION	
67 PRIN. DIAG. CD	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE
75 CODE	76 ADM. DIAG. CD	77 E-CODE	78	79 P.C. 80 PRINCIPAL PROCEDURE CODE DATE			
81 OTHER PROCEDURE CODE DATE		82 OTHER PROCEDURE CODE DATE		83 OTHER PROCEDURE CODE DATE		84 ATTENDING PHYS. ID	
85 OTHER PHYS. ID		86 OTHER PHYS. ID		87 OTHER PHYS. ID		88 PROVIDER REPRESENTATIVE	
89 DATE		90 DATE					
84 REMARKS		x <i>Opie Taylor</i> 2-1-00 I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.					

UB-92 HCFA-1450 ORIGINAL

Freeman's Family Care Raleigh, NC		2 Example #5		3 PATIENT CONTROL NO. 893		APPROVED OMB NO. 0938-0279	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM TO 010100 013100		7 COV D.		8 N-C D.	
9 C-I D.		10 L-R D.		11			
12 PATIENT NAME Atkins, Rachael				13 PATIENT ADDRESS			
14 BIRTHDATE 02251975		15 SEX		16 MS		17 DATE	
18 ADMISSION		19 ICD-9		20 ICD-9		21 D HRS	
22 STAT		23 MEDICAL RECORD NO.		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54							

Taylor's Family Care Mayberry, NC		2 Example #6		3 PATIENT CONTROL NO.		APPROVED OMB NO. 0938-0278	
5 FED. TAX NO.		8 STATEMENT COVERS PERIOD FROM 010100 TO 013100		7 COVD.		8 N-C.D.	
12 PATIENT NAME Lou, Thelma		13 PATIENT ADDRESS		9 C.I.D.		10 L.R.D.	
14 BIRTHDATE 01251942		15 SEX M		16 MS		17 DATE 091599	
18 ADMISSION TYPE 19 HR		20 TYPE 21 ICD		22 STAT 30		23 MEDICAL RECORD NO.	
32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE	
36 OCCURRENCE DATE		37 OCCURRENCE DATE		38 OCCURRENCE DATE		39 OCCURRENCE DATE	
40 VALUE CODES		41 VALUE CODES		42 VALUE CODES		43 VALUE CODES	
44 REV. CD.		45 DESCRIPTION		46 HCPCS/RATES		47 SERV DATE	
48 SERV UNITS		49 TOTAL CHARGES		50 NON-COVERED CHARGES		51	
1	599		W8251	010100	10		
2							
3	599		W8259	010100	10		
4							
5	183		W8251	010100	2		
6							
7	599		W8251	011300	19		
8							
9	599		W8259	011300	19		
10							
11	229			010100	31		
12							
13							
14							
15							

Example of an entire month of Basic ACH/PC with an authorized Enhanced Care code for eating and toileting with Therapeutic Leave for a facility with 1-30 beds

50 PAYER		51 PROVIDER NO.		52 REL. AND USE		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56	
7801200											
57 DUE FROM PATIENT											
58 INSURED'S NAME		59 P.REL.		60 CERT. - SSN - HIC - ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.			
				502020202T							
63 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION					
67 PRIN. DIAG. CD.		68 CODE		69 CODE		70 CODE		71 CODE		72 CODE	
79 P.C.		80 PRINCIPAL PROCEDURE CODE		81 OTHER PROCEDURE CODE		82 OTHER PROCEDURE CODE		83 ATTENDING PHYS. ID			
		84 OTHER PROCEDURE CODE		85 OTHER PROCEDURE CODE		86 OTHER PROCEDURE CODE		87 OTHER PHYS. ID			
84 REMARKS								88 OTHER PHYS. ID			
								89 PROVIDER REPRESENTATIVE			
								x Andy Taylor			
								88 DATE			
								2-01-00			
UB-92 HCFA-1450 ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.											

APPROVED OMB NO. 0938-0273

1 Freeman's Family Care Raleigh, NC		2 Example #7		3 PATIENT CONTROL NO. 893	
5 FED. TAX NO.		6 STATEMENT COVERED PERIOD FROM 010100 TO 013100		7 COV.D. 8 N.C.D. 9 C.I.D. 10 L.R.D. 11	
12 PATIENT NAME Doe, Jane			13 PATIENT ADDRESS		
14 BIRTH DATE 01011907		15 SEX 16 MS		17 DATE OF ADMISSION 061700	
18 OCCURRENCE CODE		19 OCCURRENCE DATE		20 OCCURRENCE SPAN	
21 D.H.R.		22 STAT		23 MEDICAL RECORD NO. 30	
24		25		26	
27		28		29	
30		31		32	
33		34		35	
36		37		38	
39		40		41	
42		43		44	
45		46		47	
48		49		50	

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	599	W8251	010100	5			1
2							2
3	599	W8259	010100	5			3
4							4
5	599	W8255	010100	5			5
6							6
7	183	W8251	010600	2			7
8							8
9	599	W8251	010800	24			9
10							10
11	599	W8259	010800	24			11
12							12
13	599	W8255	010800	24			13
14							14
15	229		010100	31			15
16							16

Example of an entire month of Basic ACH/PC and an authorized Enhanced Care code for eating and toileting and an authorized Enhanced Care code for Ambulation/Location with Therapeutic Leave for a facility with 1-30 beds

50 PAYER		51 PROVIDER NO. 7802415		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56			
DUE FROM PATIENT ▶											
57				58 INSURED'S NAME		59 P.REL. 60 CERT - SSN - HIC - ID NO. 001001001T		61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES				65 EMPLOYER NAME				66 EMPLOYER LOCATION			
67 PRIN. DIAG. CD		68 CODE		69 CODE		70 CODE		71 CODE		72 CODE	
73 CODE		74 CODE		75 CODE		76 CODE		77 ADM. DIAG. CD		78 E-CODE	
79 P.C. CODE		80 PRINCIPAL PROCEDURE DATE		81 OTHER PROCEDURE CODE		82 OTHER PROCEDURE DATE		83 ATTENDING PHYS. ID.			
84 OTHER PROCEDURE CODE		85 OTHER PROCEDURE DATE		86 OTHER PROCEDURE CODE		87 OTHER PROCEDURE DATE		88 OTHER PHYS. ID.			
89 OTHER PHYS. ID.		90 OTHER PHYS. ID.		91 OTHER PHYS. ID.		92 OTHER PHYS. ID.		93 OTHER PHYS. ID.			
94 REMARKS								95 PHYSICIAN SIGNATURE <i>Bob Freeman</i>		96 DATE 2-01-00	

UB-92 HCFA-1450 ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

APPROVED OMB NO. 0938-0273

1 Brady's Family Care Asheville, NC		2 Example #8				3 PATIENT CONTROL NO. 893																
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM TO		7 COV D.	8 N-C.D.	9 C-I.D.	10 L-R.D.	11														
		010100		011200																		
12 PATIENT NAME Butcher, Sam				13 PATIENT ADDRESS																		
14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SEC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31					
08051936							02															
32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE CODE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 A B C D		38 A B C D		39 A B C D		40 A B C D		41 A B C D		42 A B C D		
42 REV CD	43 DESCRIPTION			44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49													
1 599				W8258	010100	11																
2 599				W8257	010100	11																
3 229					010100	11																
4																						
5																						
6																						
7																						
8																						
9																						
10																						
11																						
12																						
13																						
14																						

Example of an entire month of Basic ACH/PC and an authorized Enhanced Care code for toileting for a facility with 31 or more beds when the recipient is discharged to the hospital during the month

50 PAYER		51 PROVIDER NO.		52 REL INFO	53 RATA	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56				
		7801999										
				DUE FROM PATIENT ▶								
57 INSURED'S NAME		58 REL	59 CERT. - SSN - HIC - ID NO.	60 GROUP NAME		61 INSURANCE GROUP NO.						
			905000000R									
62 TREATMENT AUTHORIZATION CODES		63 ESC	64 EMPLOYER NAME		65 EMPLOYER LOCATION							
66 PRIN. DIAG. CD.	67 CODE	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
79 P.C.		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		82 OTHER PROCEDURE CODE DATE		83 ATTENDING PHYS. ID				
								84 OTHER PHYS. ID				
								85 OTHER PHYS. ID				
86 REMARKS		87 PROVIDER REPRESENTATIVE		88 DATE								
		X Sam Brady		2-01-00								

UB-92 HCFA-1450

ORIGINAL

CERTIFICATE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

APPROVED OMB NO. 0938-0279

2 Example #9		3 PATIENT CONTROL NO. 893	
Brady's Family Care Asheville, NC			
5 FED. TAX NO.	6 STATEMENT COVERED PERIOD FROM TO	7 COVD.	8 N.C.D.
	012000 013100		
12 PATIENT NAME Butcher, Sam		13 PATIENT ADDRESS	
14 BIRTHDATE	15 SEX	16 MS	17 DATE
08051936			30
18 ADMISSION TO HOSPITAL		21 D HR	
		22 STAT	
		23 MEDICAL RECORD NO.	
24		25	
26		27	
28		29	
30		31	
32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE
36		37	
38		39	
40		41	
42		43	
44		45	
46		47	
48		49	

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 599		W8258	012000	12			
2							
3 599		W8257	012000	12			
4							
5 229			012000	12			
6							
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Example of the same recipient from Example #8 that has returned to the ACH from the hospital

50 PAYER		51 PROVIDER NO.	52	53	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
		7801999					
57		DUE FROM PATIENT					
58 INSURED'S NAME		59 P.REL.	60 CERT. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.		
			905000000R				
63 TREATMENT AUTHORIZATION CODES		64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION			
67 PRIN. DIAG. CD	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE
75 ADM. DIAG. CD	76 E-CODE	78					
79 P.C	80 PRINCIPAL PROCEDURE CODE	81 OTHER PROCEDURE CODE	82 OTHER PROCEDURE CODE	83 ATTENDING PHYS. ID			
	84 OTHER PROCEDURE CODE	85 OTHER PROCEDURE CODE	86 OTHER PROCEDURE CODE	87 OTHER PHYS. ID			
84 REMARKS				85 PHYSICIAN (REPRESENTED)			
				X Jan Brady			
				86 DATE			
				2-01-00			

UB-92 HCFA-1450 ORIGINAL

1 CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.